

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

11059

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11059

X TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN lb 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Forest Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 South Kelly Avenue			d. STREET ADDRESS Sandy Hook Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lonza Mack Andrews		First	Middle	Last	4. DATE OF DEATH August 14, 1967	Month Doy Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 2, 1905	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian			10b. KIND OF BUSINESS OR INDUSTRY High School			11. BIRTHPLACE (State or foreign country) Alleghany Co., North Carolina	
13. FATHER'S NAME Ralph T. Andrews			14. MOTHER'S MAIDEN NAME Ellen Rector			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-14-6718			17. INFORMANT (Wife) Mrs. Lura M. Andrews	
Address RFD #1 Forest Hill, Md. 21050							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bel Air, Harf. Co., Md. 21014	(County) Bel Air, Harf. Co., Md. 21014	(State) Bel Air, Harf. Co., Md. 21014
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Gerald C. Palmer M.D. EXAMINER'S NAME (Type) S. Main St., Bel Air, Md. 21014							
CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be 14-15-NL ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Joseph William Foster							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		23d. LOCATION (City or Town) Bel Air, Harf. Co., Md. 21014		
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE
				DATE AUG 16 1967			

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overhead

0-100% e LM control overheat info

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status info local info

status info LM info

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

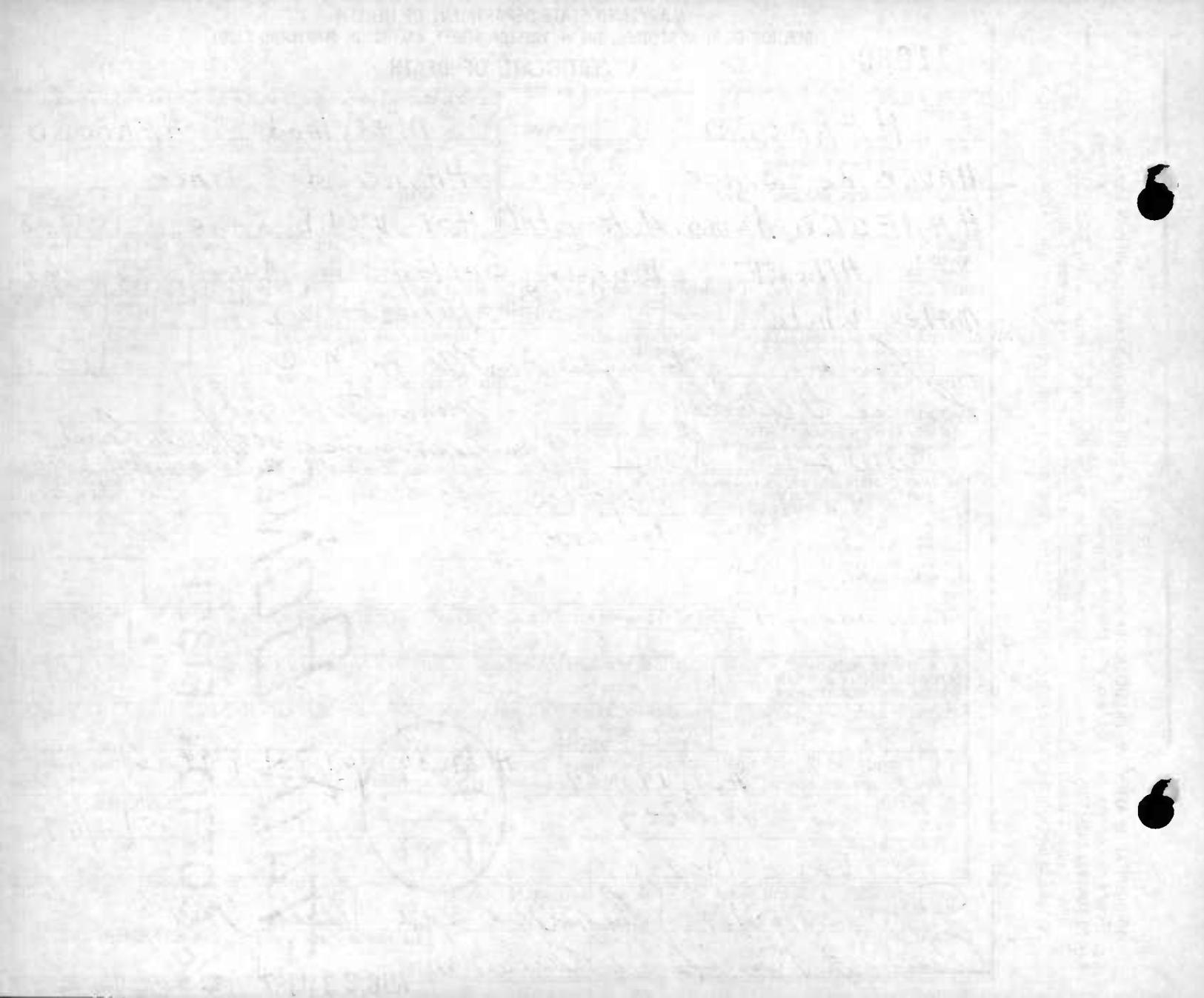
11060

CERTIFICATE OF DEATH

11060

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hause de Grace		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Albert	Middle Eugene	Last Briley
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/16/1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Bloomingdale Park	11. BIRTHPLACE (County & State, or foreign country) Marion N.C.
13. FATHER'S NAME Bonnie G. Bailey		14. MOTHER'S MAIDEN NAME Minnie Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW 2		16. SOCIAL SECURITY NO. mb	17. INFORMANT Mrs Sadie Vanover 401 Well Lane
			Address Laurel Md. 21078
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Steptalic coma. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 16, 1967, to Aug 19, 1967 that (I) (we) last saw the deceased alive on Aug 19, 1967, and that death occurred at [REDACTED] M, from causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED 8/20/67	
22c. PHYSICIAN'S NAME (Type) Lajos Mezei		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/22/67	23c. NAME OF CEMETERY OR CREMATORIAL BLDG. Loudon Park Nec.
23d. LOCATION (City or Town) (County) (State) Beltsville Md.			
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR
			DATE
			25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11061

CERTIFICATE OF DEATH

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11061			
1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de Grace		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SIRHT		First	Middle
4. DATE OF DEATH Month August Day 31 Year 1967		Last	Month
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-12-1894		9. AGE (In years last birthday) 73 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Isaac H. Stearn	
14. MOTHER'S MAIDEN NAME Josephine Siler		15. ADDRESS Address	
16. SOCIAL SECURITY NO. —		17. INFORMANT Harriett Brown, Charlestown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.2		INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Failure (c) Cardiac Asthma		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21. I certify that (I) (this hospital) attended the deceased from Aug 27, 1967 , to Aug 30, 1967 , that (I) (we) last saw the deceased alive on Aug. 30, 1967 , and that death occurred at 6:30 M, from causes and on the date stated above.		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
22a. SIGNATURE Clarence J. Benson		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22b. DATE SIGNED Aug 31-67		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Port Deposit (County) Md. (State) Md.		20g. ADDRESS Port Deposit, Md.	
21. PHYSICIAN'S NAME (Type) Clarence J. Benson MD.		22. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-4-1967	
23c. NAME OF CEMETERY OR REMATORIAL St. Marys Cem.		23d. LOCATION (City or Town) Buryville, Md. (County) Md. (State) Md.	
24. FUNERAL DIRECTOR Lee A. Patterson Son, Perryville, Md.		25a. RECEIVED BY REGISTRAR SEP 6 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Patterson			

ET 4881-31-5

6218

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smooth

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single

white

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OH

bill Tracy, D.T. & M. marsh, I. marsh
reddish and rough the top & back
blackish with white on the sides.

MARYLAND STATE DEPARTMENT OF HEALTH
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NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 only should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

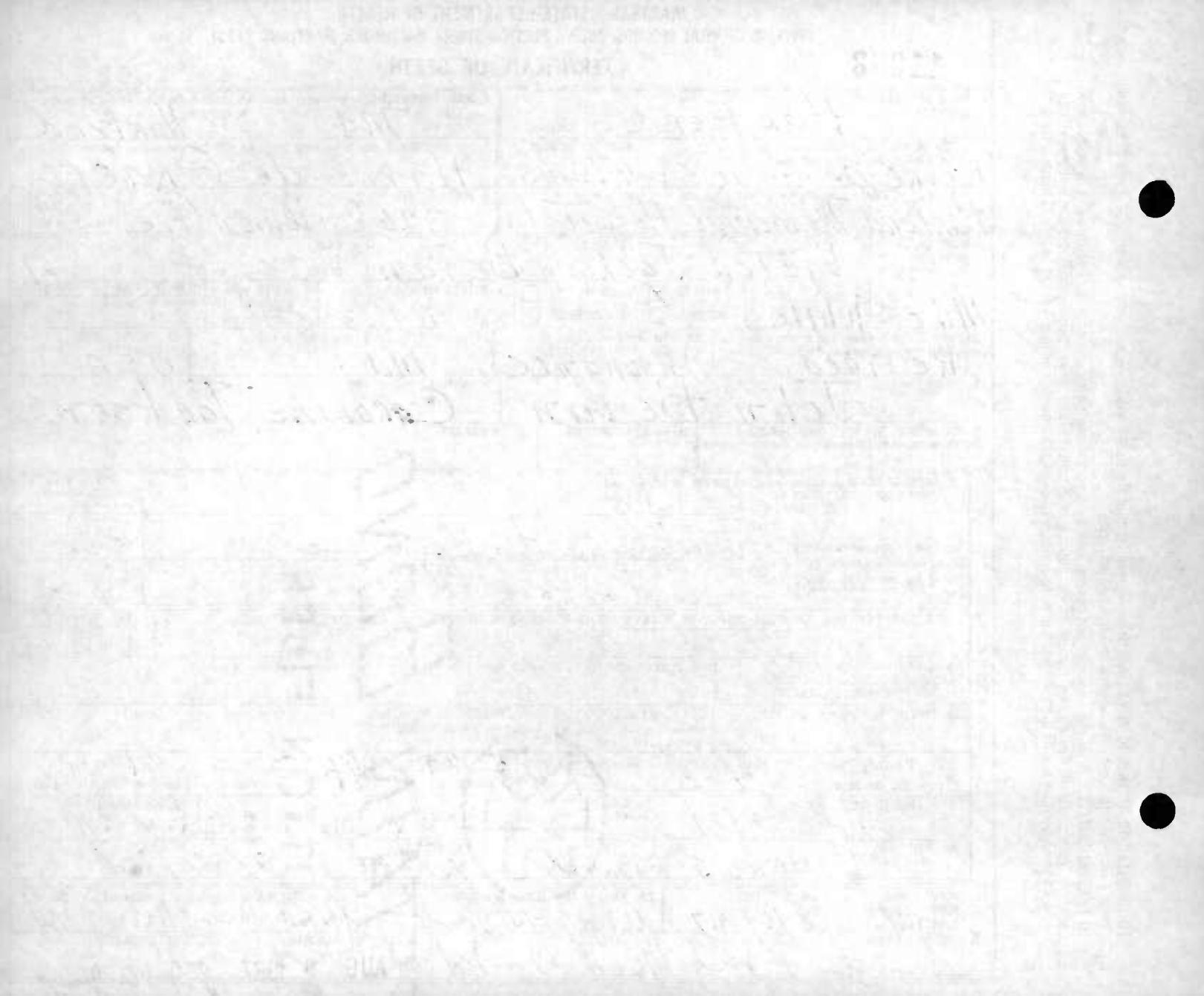
VR A15 (4
25M 1/67)

1. PLACE OF DEATH

CERTIFICATE OF DEATH

11062

1. PLACE OF DEATH o. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		c. LENGTH OF STAY IN lb 67 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 326 S. Union Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH Month Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7/1908	9. AGE (In years lost birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10b. KIND OF BUSINESS OR INDUSTRY Insurance		10c. BIRTHPLACE (County & State, or foreign country) Md.	
13. FATHER'S NAME John Bevan		14. MOTHER'S MAIDEN NAME Caroline Jackson		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CVA 443X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. } (b) arterio sclerosis hypertension (c) Cardio Vasc. disease					
INTERVAL BETWEEN ONSET AND DEATH dead					
5 yrs					
3 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-29, 1967, to 8-3, 1967, that (I) (we) last saw the deceased alive on 8-3 1967, and that death occurred at 8-3 M, from causes and on the date stated above					
220. SIGNATURE Edward J. Simon		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-4-67	
22c. PHYSICIAN'S NAME (Type) EDWARD J. SIMON		22d. ADDRESS HARRE DE GRACE, Ind.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/6/1967		23c. NAME OF CEMETERY OR CREMATORIUM Angel Hill Cemetery	
24. FUNERAL DIRECTOR Connally + Son, Harford Grace, Md.		ADDRESS		23d. LOCATION (City or Town) (County) (State) Harford Grace, Harford, Md	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DATE AUG 9 1967		RECEIVED ON			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

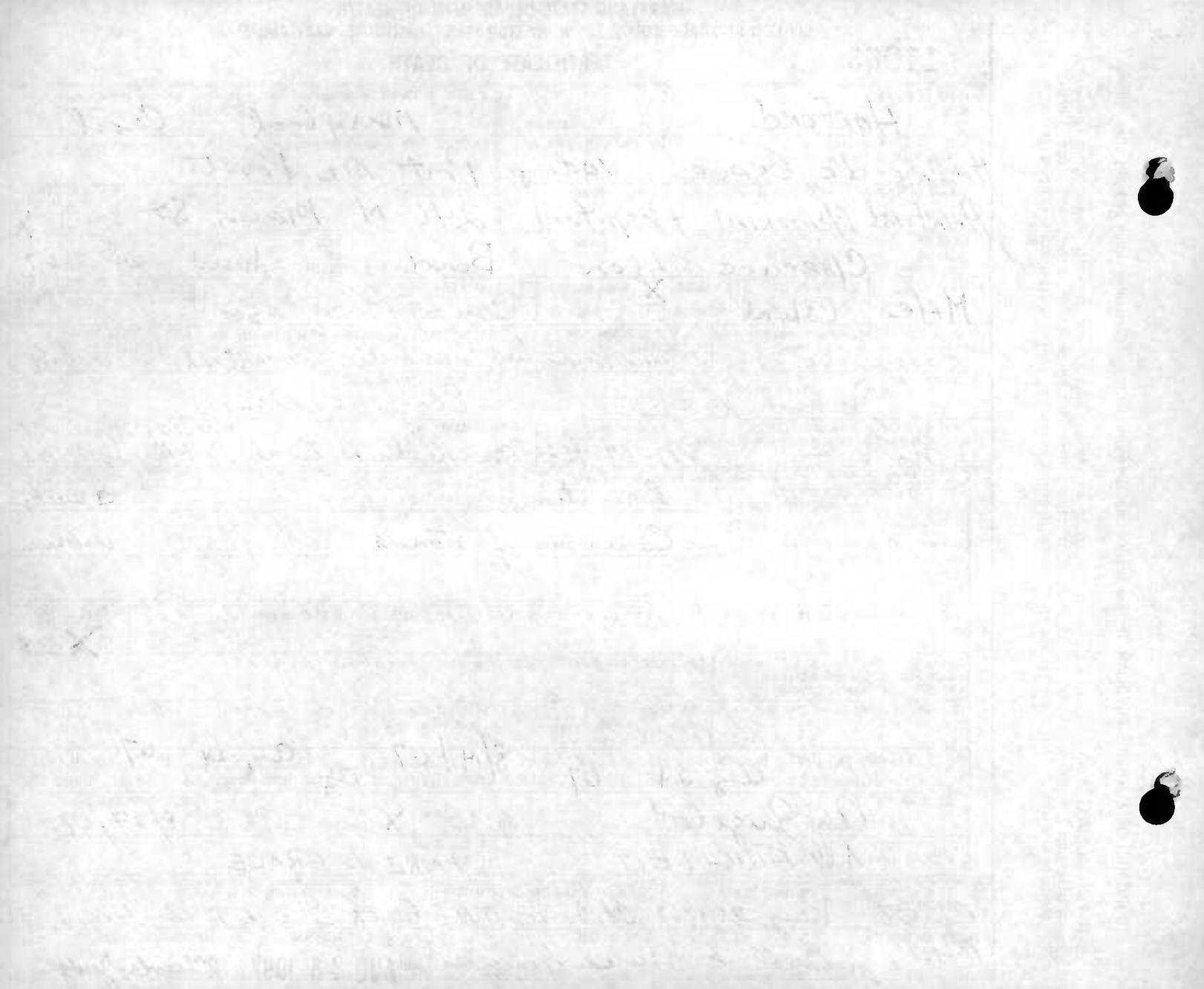
10 hours after death
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 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event within 72 hours after death.

11063

CERTIFICATE OF DEATH

11063

1. PLACE OF DEATH o. COUNTY Hartford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE		c. LENGTH OF STAY IN lb 10days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		d. STREET ADDRESS 246 N Main St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hartford Memorial Hosp. & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clarence	Middle Leon	Last Bond
4. DATE OF DEATH	Month August	Doy 24	Year 1967
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1902
9. AGE (In years lost, birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (R.P.)	10b. KIND OF BUSINESS OR INDUSTRY Ashdown Proving Gr.	11. BIRTHPLACE (County & State, or foreign country) Churchville, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Bond	14. MOTHER'S MAIDEN NAME Elijah Turner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-09-4538	17. INFORMANT Mrs. Bella B. Bond, Port Deposit, Md.	Address 246 Main St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Quanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of stomach DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Gravelly Hill, Hartford, Md.
21. I certify that (I) (this hospital) attended the deceased from Aug 24, 1967 , to Aug 24, 1967 , thot (I) (we) last saw the deceased alive on Aug 24, 1967 , and that death occurred of 7:30 AM , M, from causes and on the date stated above.			
22a. SIGNATURE A.W. Grigoleit	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT	22d. ADDRESS HAURE de GRACE		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 28, 1967	23c. NAME OF CEMETERY OR CREMATORIAL St. James A.M.E. Cemetery	23d. LOCATION (City or Town) Gravelly Hill, Hartford, Md.
24. FUNERAL DIRECTOR Otelia J. Bullock, Haure de Grace, Md.	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 25M 1/67	DATE Aug 28, 1967		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11064

CERTIFICATE OF DEATH

11064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace, Md.	c. LENGTH OF STAY IN lb 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXX . Jarrettsville 121	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citizens Nursing Home		d. STREET ADDRESS Anderson Lane	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary	First Lulua	Middle Bosley	Last
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-9- 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) XX. Street, Maryland
13. FATHER'S NAME Charles Kennedy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No ---		16. SOCIAL SECURITY NO. 219-16-5592	17. INFORMANT Sarah Elizabeth Rigdon Address Sherman M. Bosley Forest Hill, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ch. Arteriosclerotic Cardiac Disease</i> DUE TO (c) <i>Disease</i>		21050 INTERVAL BETWEEN ONSET AND DEATH Sept 20 death ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Post Cholecystectomy Convalescence</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 1966, to <i>Aug 2</i> , 1967, that (I) (we) last saw the deceased alive on <i>Aug 1</i> , 1967, and that death occurred at <i>11:53 AM</i> , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22o. SIGNATURE <i>Willard P. Hudson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/2/67
22c. PHYSICIAN'S NAME (Type) <i>WILLARD P. HUDSON</i>		22d. ADDRESS <i>FOREST Hill, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8/5/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Highland Presbyterian</i>	23d. LOCATION (City or Town) (County) (State) <i>Street, Maryland</i>
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.		25o. REC'D BY REGISTRAR DATE AUG 4 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		21084	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

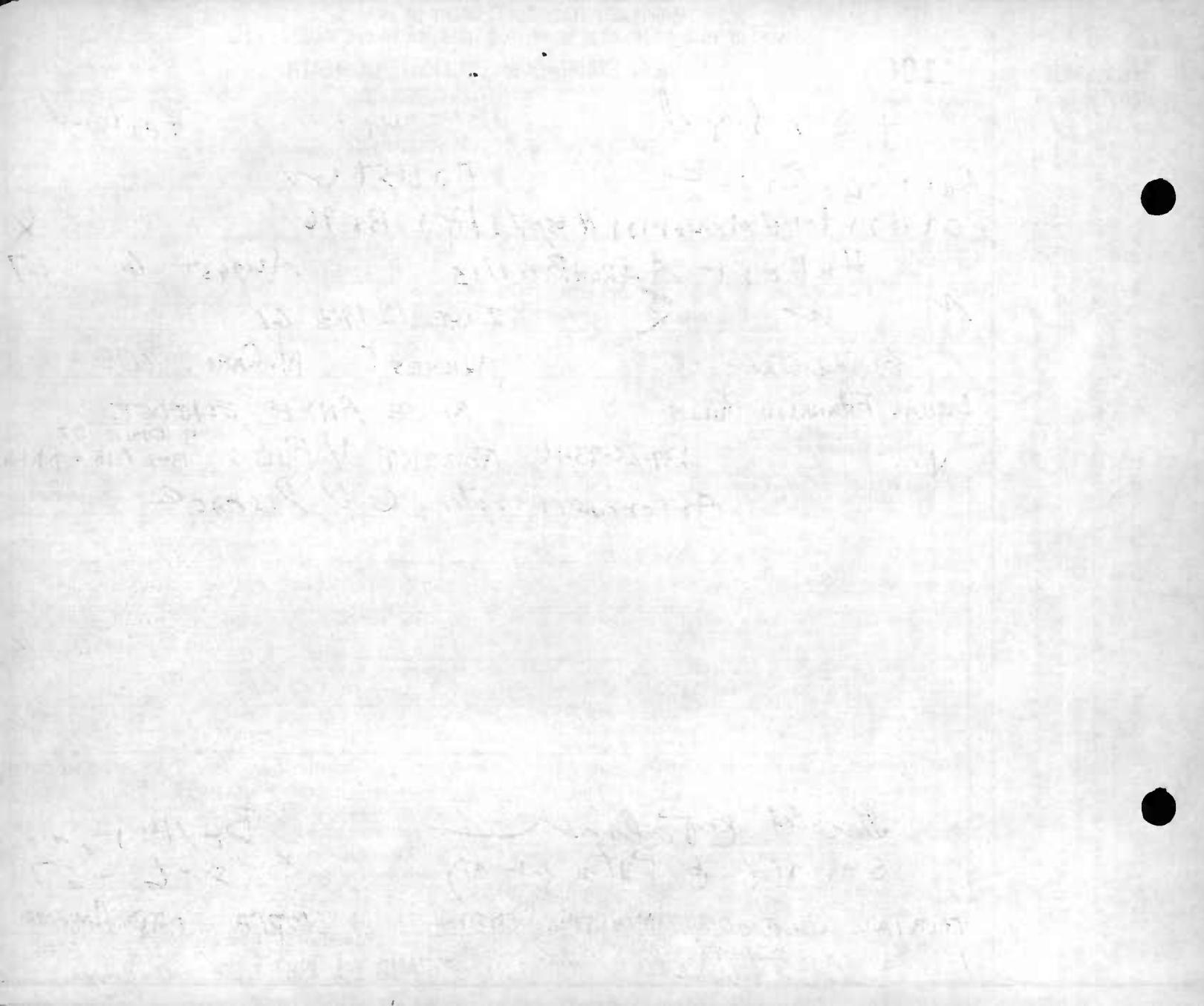
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11065		11065	
1. PLACE OF DEATH a. COUNTY <i>Hagerstown</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		b. COUNTY <i>Hagerstown</i>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fallston</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dorothy Foy Memorial Hospital</i>		d. STREET ADDRESS <i>172 Bx 96</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Hubert Aaron Bullis</i>		First	Middle
4. DATE OF DEATH Month <i>August</i> Day <i>6</i> Year <i>1967</i>		Lost	Month
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) <i>61 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Wilkes Co. N. CARO</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Lewis Franklin Bullis</i>		14. MOTHER'S MAIDEN NAME <i>Roxie Anne Ellidge</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>237-05-9346</i>	
17. INFORMANT <i>ROBERT V. Bullis</i>		Address <i>3 Dixie Dr Bel Air - MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>After-muscular rotatory CV Disease</i>			
4221 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Harold E. Palmer</i> M.D.	
ACTUAL SIGNATURE <i>Harold E. Palmer</i> EXAMINER'S NAME (Type) <i>Harold E. Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>8-6-67</i>	
22. DATE SIGNED <i>Be/HI 11/11/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>Aug 10, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>MOUNTAIN CHRISTIAN</i>		23d. LOCATION (City or Town) (County) (State) <i>JOPPA MD HARFORD</i>	
24. FUNERAL DIRECTOR <i>W.H. Archer, Benson</i>		ADDRESS <i>701 W. 11th St.</i>	
25. REC'D BY REGISTRAR <i>AUG 11 1967</i>		26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11066

CERTIFICATE OF DEATH

11066

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Harford MARYLAND		Md Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Harvre de Grace	8 hrs.	'Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Harford Memorial Hospital	18 Grant Street		12-1
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	4. DATE OF DEATH Month Year
Male	White	Connolly	August 20 1967
5. SEX	6. COLOR OR RACE	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 19 August 67
7. MARRIED NEVER MARRIED WIDOWED DIVORCED	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours 8	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Havre de Grace, Md.	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Robert J. Connolly	14. MOTHER'S MAIDEN NAME Renalda Szarmack		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No	16. SOCIAL SECURITY NO. N/A	17. INFORMANT Robert J. Connolly, Same as 2 C&D	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 <u>Hyaline Membrane disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 8 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-19, 1967, to 8-20, 1967, that (I) (we) last saw the deceased alive on 8-20, 1967, and that death occurred at 5 AM, from causes and on the date stated above.			
22a. SIGNATURE <i>John D. Yen</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/20/67
22c. PHYSICIAN'S NAME (Type) JOHN D. YEN		22d. ADDRESS HAURE DE GRACE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 20 Aug. 67	23c. NAME OF CEMETERY OR CREMATORIAL Gates of Heaven Cemetery, Lewiston, N.Y.
24. FUNERAL DIRECTOR <i>Fred J. Tarring</i>		ADDRESS Tarring Funeral Home, Aberdeen, Md.	25a. REC'D BY REGISTRAR DATE AUG 23 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Yen</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11067

CERTIFICATE OF DEATH

11067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Aberdeen		c. LENGTH OF STAY IN 16 30 days 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS 308 Oak Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ethel		First Ethel	Middle Sarah
Last Fisher		4. DATE OF DEATH August 8 1967	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Hostess		10b. KIND OF BUSINESS OR INDUSTRY Officers Club	8. DATE OF BIRTH Nov 4, 1907
13. FATHER'S NAME Buchanan		9. AGE (In years last birthday) 59 yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-3004	17. INFORMANT Address Mr Joseph D Fisher 308 Oak St Edgewood Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: 177X IMMEDIATE CAUSE (a) Carcinoma, pancreas; metastasis, to portal vein, DUE TO liver, ? Spleen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hepatic vein and pelvic vein thrombosis, recent DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Kirk Army Hospital, APG, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Mark J. Epstein		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MARK J. EPSTEIN, CPT, MC		22d. ADDRESS Kirk Army Hospital, APG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 10, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Cokesbury Memorial Cemetery
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21000		ADDRESS	25a. REC'D BY REGISTRAR AUG 11 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11068

item #23D G392, 8/25/67 1a CERTIFICATE OF DEATH

11068

1. PLACE OF DEATH o. COUNTY HARRFORD Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville-rural		c. LENGTH OF STAY IN 1b 10yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville Md. 21087 rural
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2800 Jerusalem Road		d. STREET ADDRESS 2800 Jerusalem Road Kingsville	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Hubert	Middle W.	4. DATE OF DEATH Aug 1 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Selfemployed	9. AGE (In years lost birthday) 62 yrs.
13. FATHER'S NAME Walter Gaddi's		14. MOTHER'S MAIDEN NAME Laura Hammontree	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-7496	17. INFORMANT Mr William H. Gaddi's 2800 Jerusalem Road
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY INFARCTS 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA (c) CARCINOMA of URINARY BLADDER Gr II		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 16, 1967, to AUG 1, 1967, that (I) (we) last saw the deceased alive on Aug 1 1967, and that death occurred at 9:30 PM, from causes and on the date stated above.		22b. DATE SIGNED Aug 2 1967	
22c. PHYSICIAN'S NAME (Type) THEODORE E. EVANS MD		22d. ADDRESS 9660 BELAIR RD. BALTO 36 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-5-1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Christian Cemetery
24. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	25a. REC'D BY REGISTRAR AUG 7 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11069

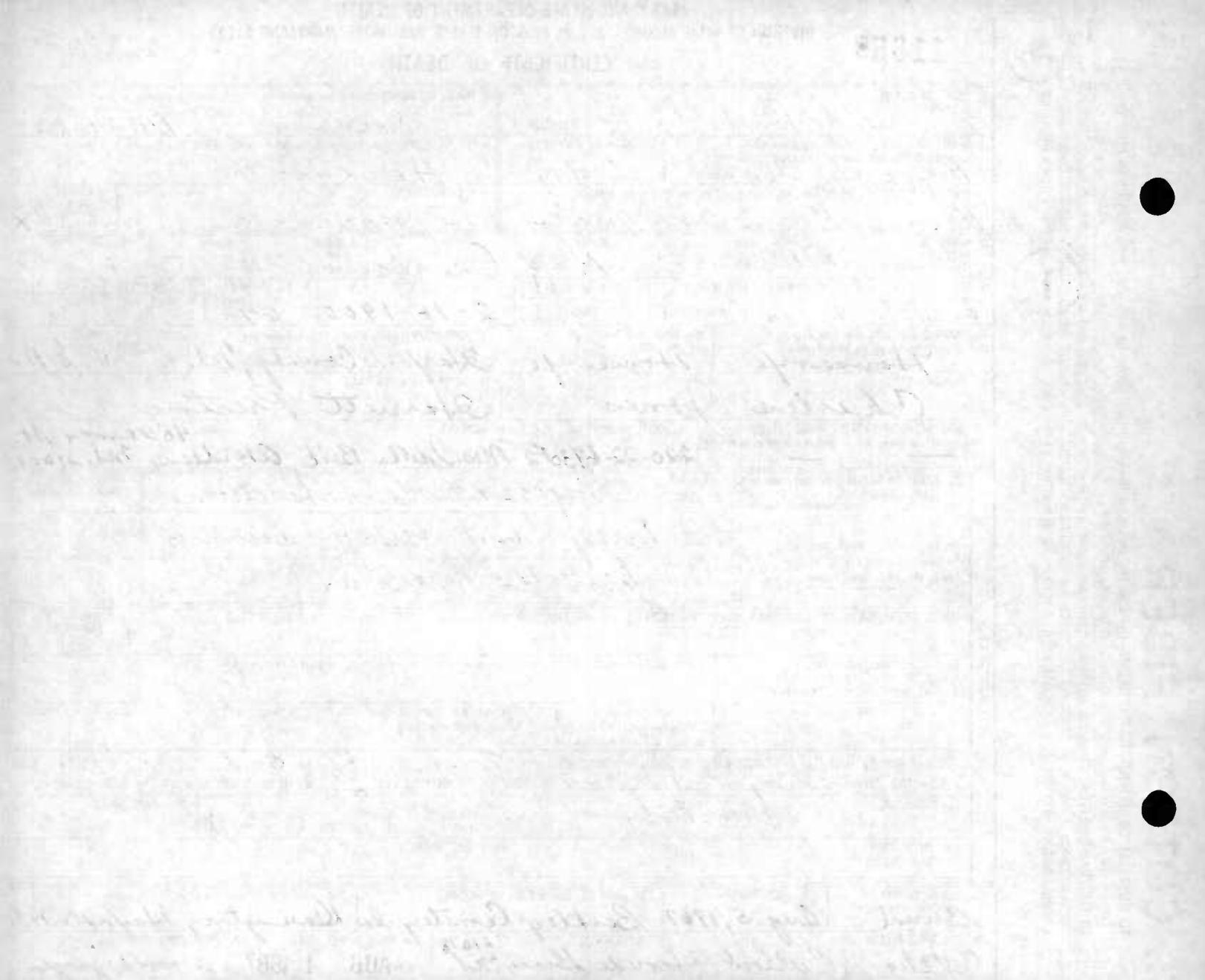
11069

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE				
<i>HARFORD</i>		MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				
<i>HAURE de GRACE</i>		16 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
<i>HARFORD MEMORIAL Hospital</i>		<i>15 HANOVER</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First	Middle			
<i>Florence</i>		<i>Mary</i>	<i>GRIMES</i>			
4. DATE OF DEATH		Month	Day Year			
<i>August 1 1967</i>						
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
<i>Female</i>		<i>Negro</i>	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	<i>2-16-1900</i>	<i>67 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>		<i>Housewife</i>		<i>HARFORD COUNTY, MD.</i>		<i>V. S. A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
<i>Charles Jones</i>		<i>Harriett Preston</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>489 Envoy St.</i>
<i>—</i>		<i>220-22-6730</i>		<i>Mrs. Idella Beck, Aberdeen, Md. 21001</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH
<i>260X</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Myocardial infarction</i>		
(b)		DUE TO		<i>Cong. heart failure decomps.</i>		
(c)		DUE TO		<i>Diabetes mellitus</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
Hour o.m. p.m.		19				
21. I certify that (I) (this hospital) attended the deceased from <i>7-17</i> , 19 <i>67</i> to <i>8-1</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>8-1</i> , 19 <i>67</i> , and that death occurred on <i>8-1</i> , 19 <i>67</i> M, from causes and on the date stated above.						
22a. SIGNATURE <i>Mosser</i>						22b. DATE SIGNED
M.D. ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		<input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
<i>Burial</i>		<i>Aug. 5, 1967</i>		<i>Berkley Cemetery Inc.</i>		<i>Darlington, Harford Co. Md.</i>
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<i>Otels J. Bullock, HARVE de GRACE MD.</i>		<i>21078</i>				<i>Charles Judge</i>
				DATE AUG 4 1967		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11070

11070

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford Rural		c. LENGTH OF STAY IN lb 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford, Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Olive		First	Middle	Last	4. DATE OF DEATH August 8 1967	Month	Day Year
5. SEX F	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1909	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Perry Hall, Md.	
13. FATHER'S NAME Albert Schroeder				14. MOTHER'S MAIDEN NAME Rose Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. -----		17. INFORMANT Leslie G. Harrison Whiteford, Md.		
Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X <i>Carcinomatous,</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary in Breast</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 4, 1967 , to Aug. 8, 1967 , that (I) (we) last saw the deceased alive on Aug. 4, 1967 , and that death occurred at 10:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Norman H. Gemmill</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/10/67
22c. PHYSICIAN'S NAME (Type) Norman H. Gemmill				22d. ADDRESS Stewartstown, Penna.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Md.		
24. FUNERAL DIRECTOR John H. Harkins				ADDRESS Delta, Penna.	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66				DATE AUG 11 1967			

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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11071

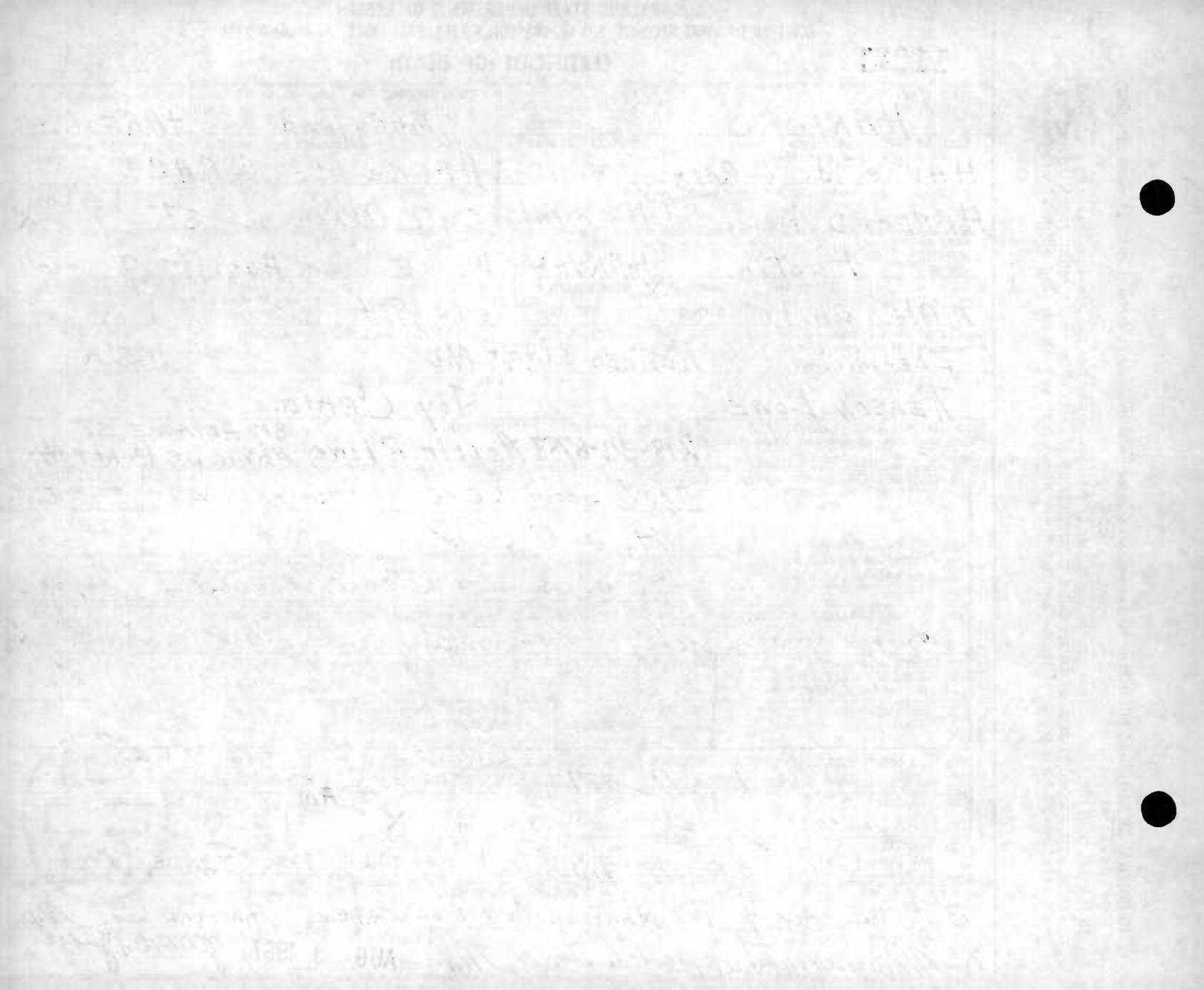
CERTIFICATE OF DEATH

11071

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1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE 6 DAYS		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS 317 Alliance St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Austin	Middle HARVEY	Last LOWE
4. DATE OF DEATH	Month August	Day 7	Year 1967
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 4 1904
9. AGE (In years lost birthday) 62 yrs.		10. KIND OF BUSINESS OR INDUSTRY RETIRED P.P.M.A. MD	11. BIRTHPLACE (County & State, or foreign country) 317 ALLIANCE ST
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME REASON LOWE	
14. MOTHER'S MAIDEN NAME Joy CRAIG		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. 218-32-6788		17. INFORMANT HELLIE R. LOWE, HAVRE DE GRACE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Massane Cerebro vascular accident INTERVAL BETWEEN ONSET AND DEATH 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO A. S. C. V. D. ages - lost. (c) DUE TO Emphysema & Chronic Bronchitis ages -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Large gastric ulcer penetrating into pancreas			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 22, 1967, to Aug 7, 1967, that (I) (we) last saw the deceased alive on Aug. 7 1967, and that death occurred at 505 AM from causes and on the date stated above.			
22a. SIGNATURE Charles J. Foley Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) CHARLES J. FOLEY JR.		22d. ADDRESS HAVRE de GRACE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Aug. 9, 1967		23b. DATE THEREOF Aug. 9, 1967	23c. NAME OF CEMETERY, OR CREMATORIAL GARDENS
24. FUNERAL DIRECTOR Y-Madison Mitchell, Havre de Grace, Md.		ADDRESS	23d. LOCATION (City or Town) HARFORD Co., MD. (County) (State)
25a. REC'D BY REGISTRAR AUG 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE AUG 9 1967			



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #6392 97167 ph

CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville	c. LENGTH OF STAY IN 1b 2 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville	b. COUNTY HARFORD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Amoss Mill road		d. STREET ADDRESS Amoss Mill road				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CHARLES E. MAGNESS SR.		First	Middle			
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) Maryland		9. AGE (In years (at birthday) 84 yrs.				
13. FATHER'S NAME Steven Magness		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-6909	17. INFORMANT Family Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic Heart Disease stating the underlying cause (c) Uncontrolled arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Moreland Memorial Pk.	20f. (City or town) Baltimore Co. Md.	(County) Baltimore Co.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from August 24, 1967 to 27 August, 1967 , that (I) (we) last saw the deceased alive on 24 August, 1967 , and that death occurred at 5:00 P.M. from causes and on the date stated above.						
22a. SIGNATURE Reginald B. Bennett		M.D. <input type="checkbox"/> ATTENDING PHYS. Reginald B. Bennett	22b. DATE SIGNED 28 August 1967	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-30-67	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Pk.	23d. LOCATION (City or Town) Baltimore Co. Md.	(County) Baltimore Co.	(State) Md.
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

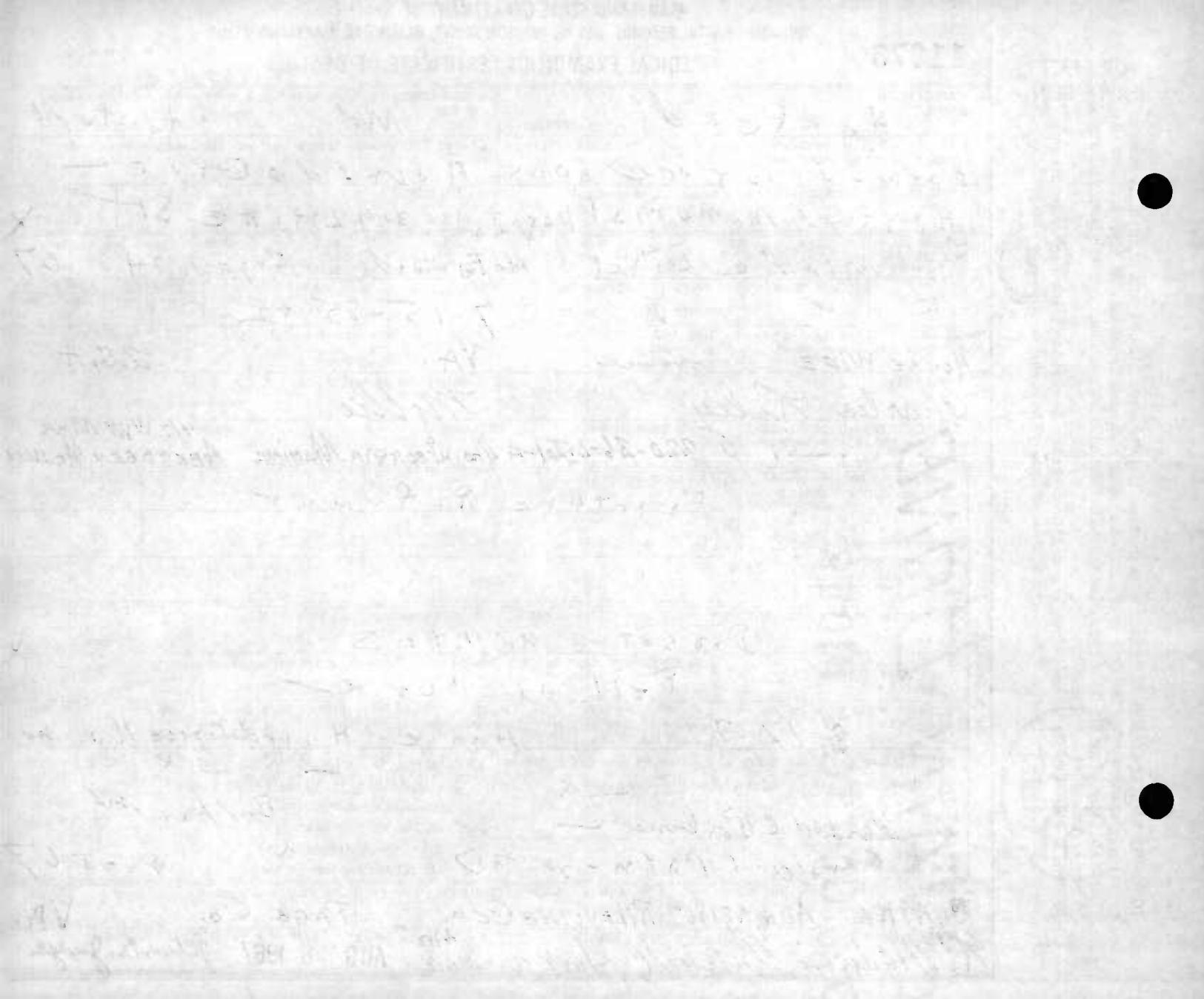
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford-Gardner 60 days		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital 314 Lefante St		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Minnie	Middle Ethel	Last McFarland
4. DATE OF DEATH	Month August	Year 1967	Day 24
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-85
9. AGE (In years 82 last birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) VA
12. CITIZEN OF WHAT COUNTRY U.S.A.	13. FATHER'S NAME Charles Riley	14. MOTHER'S MAIDEN NAME Mollie	Address 417 WYN MAR Aberdeen Mo. 21001
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-26-0561-A	17. INFORMANT Mrs. GEORGIA MANINA	18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) Address
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 9040 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)		Friture R. Farmer INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes Mellitus			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 8-18-67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Harford-Gardner Hs. No
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald E Palmer	CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, MD		
EXAMINER'S NAME (Type) Georgia E Palmer-72	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 8-25-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF AUG 27 1967	23c. NAME OF CEMETERY OR CREMATORIUM RILEYVILLE CEM.	23d. LOCATION (City or Town) (County) (State) PAGE Co. VA.
24. FUNERAL DIRECTOR R. Madison Mitchell, Harford-Gardner	ADDRESS Mo.	25a. REC'D BY REGISTRAR AUG 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
25c. DATE			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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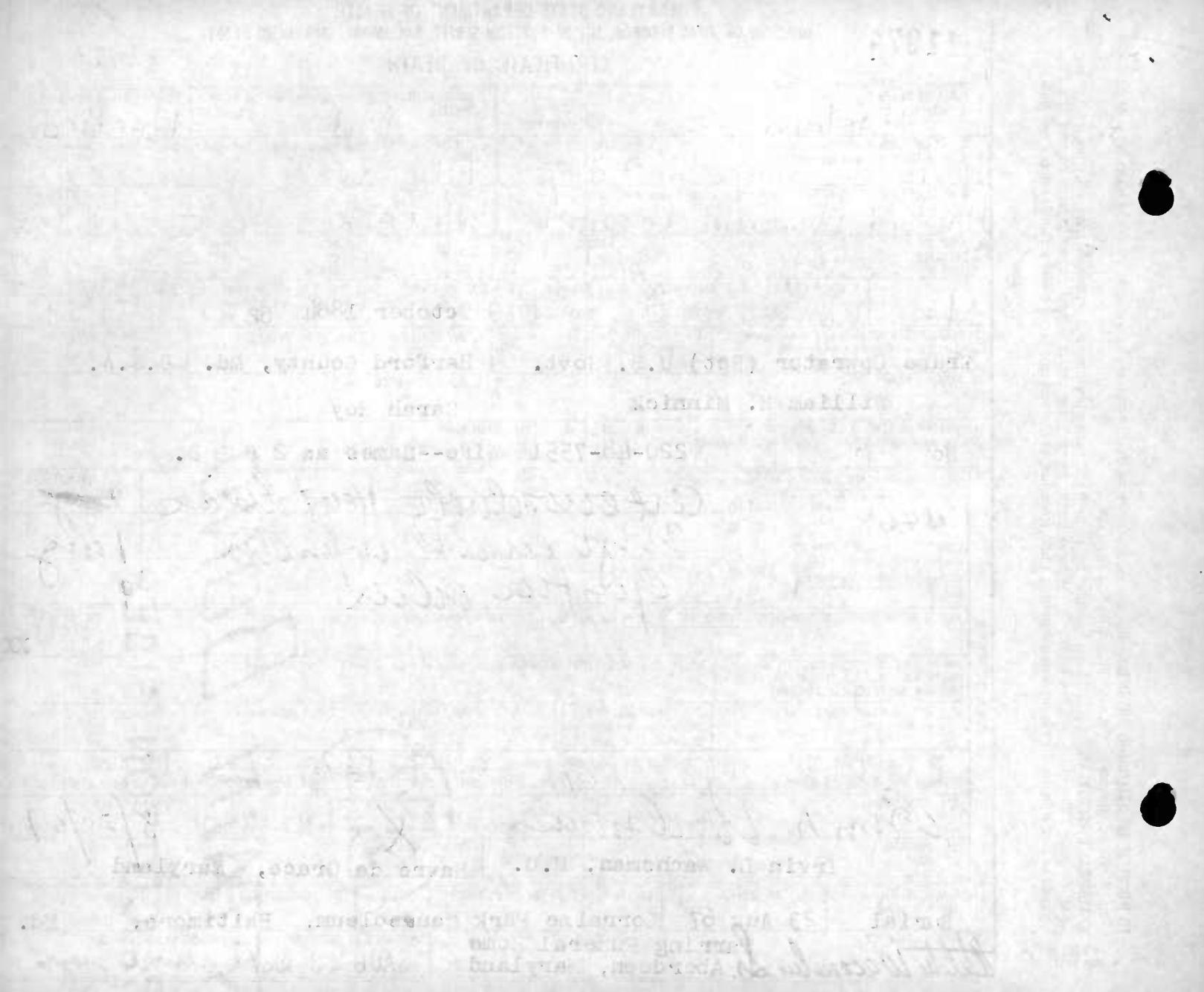
CERTIFICATE OF DEATH

11074

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1. PLACE OF DEATH o. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS 214 Parke Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Charles Minnick		First	Middle
4. DATE OF DEATH 8 - 20 1967		Month	Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9 October 1884		9. AGE (In years lost birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator (Ret) U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Minnick		14. MOTHER'S MAIDEN NAME Sarah Hoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-48-7551	
17. INFORMANT Wife--Same# as 2 C & D.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4201 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last: (b) Arteriosclerotic heart disease (c) Myocardial infarction Gastric ulcer			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/13 1967 to 8/20 1967 , that (I) (we) last saw the deceased alive on 8/20 1967 , and that death occurred at 5 AM , from causes and on the date stated above.		22b. DATE SIGNED 8/20/67	
22c. PHYSICIAN'S NAME (Type) Irvin L. Wachsman, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Havre de Grace, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Aug 67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lorraine Park Mausoleum, Baltimore, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Tarring Funeral Home Aberdeen, Maryland		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE DATE AUG 23 1967



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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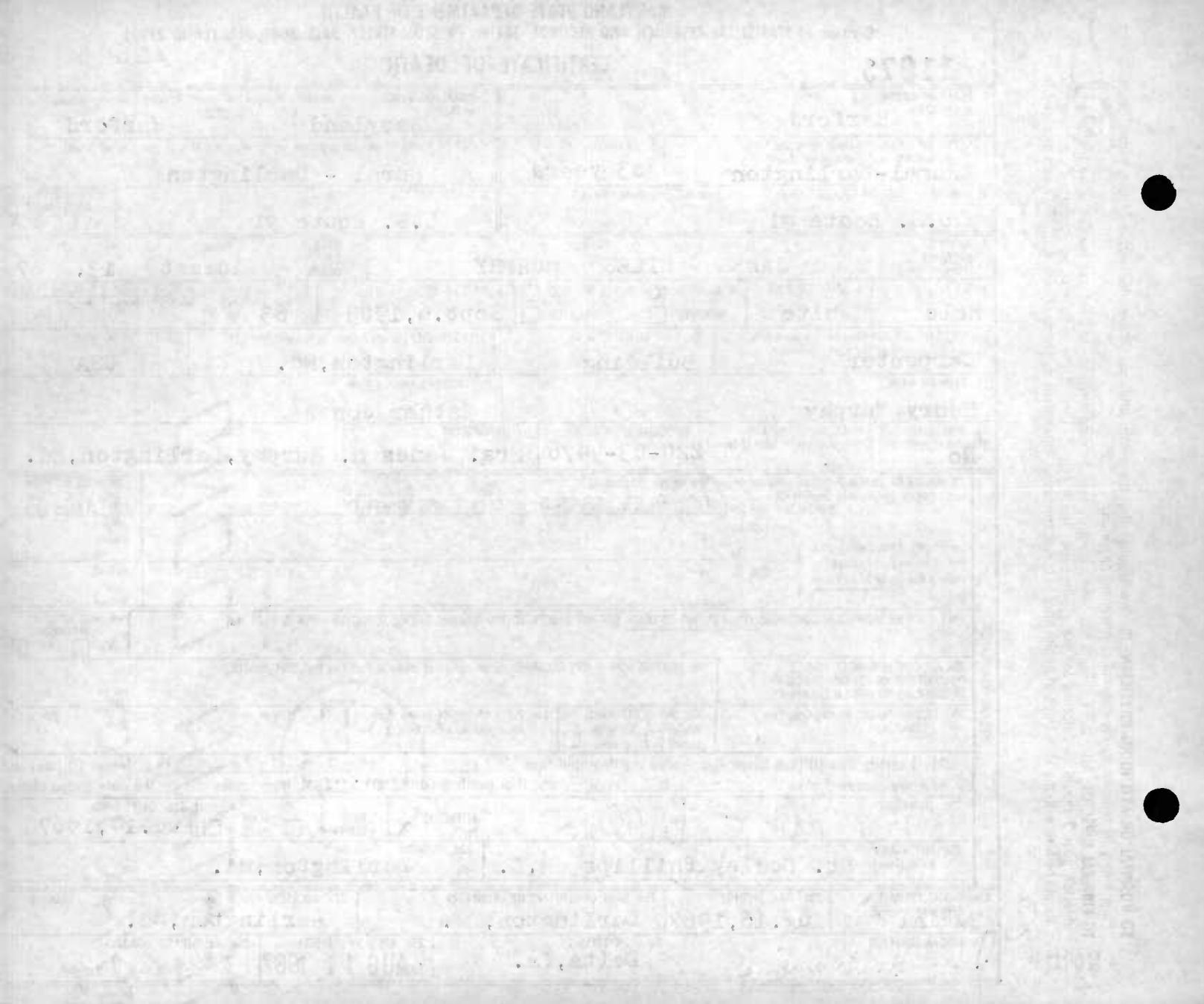
CERTIFICATE OF DEATH

11075

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1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Darlington		c. LENGTH OF STAY IN lb 63 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. NAME OF DECEASED (Type or print) JAMES MILES MURPHY		4. DATE OF DEATH Month August	Year 13, 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (County & State, or foreign country) Darlington, Md.
13. FATHER'S NAME Henry Murphy		14. MOTHER'S MAIDEN NAME Esther Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-9476	17. INFORMANT Mrs. James M. Murphy, Darlington, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Darlington, Md.
21. I certify that (I) (this hospital) attended the deceased from 8/1 , 1967, to 8/13 , 1967, that (I) (we) last saw the deceased alive on 8/6 , 1967, and that death occurred at 12:15 P.M. from causes and on the date stated above.		22b. DATE SIGNED Aug. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Dudley Phillips M.D.		22d. ADDRESS Darlington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 16, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Darlington, Md.
24. FUNERAL DIRECTOR <i>John H. Hartman</i>		ADDRESS Delta, Pa.	25a. REC'D BY REGISTRAR DATE AUG 17 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11076

CERTIFICATE OF DEATH

11076

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pylesville		c. LENGTH OF STAY IN lb Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pylesville	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM THOMAS NEAL		First	Middle
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
13. FATHER'S NAME Charles Neal		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-5004	
17. INFORMANT		Address Mrs. E.M. Neal, Pylesville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH	
(b) Coronary insufficiency & etc.			
(c) Myocarditis, hypertension,			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stewartstown, Penna.
21. I certify that (I) (this hospital) attended the deceased from July 29, 1967 , to Aug. 1, 1967 that (I) (we) lost saw the deceased alive on July 29, 1967 and that death occurred at Stewartstown, Penna. from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Norman H. Gemmill		22b. DATE SIGNED 8/2/67	
22c. PHYSICIAN'S NAME (Type) Norman H. Gemmill		22d. ADDRESS Stewartstown, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/67	23c. NAME OF CEMETERY OR CREMATORIAL McKendree Meth. Cem.
24. FUNERAL DIRECTOR Kenneth W. Oberbauer		23d. LOCATION (City or Town) (County) (State) Airville, York Co., Pa.	
		ADDRESS Stewartstown, Pa.	
		25a. REC'D. BY REGISTRAR AUG 4 1967	25b. REGISTRAR'S SIGNATURE Charles Juergs

DOSE

100 mg. Lysine

100 mg. Ascorbic

100 mg. Thiamine

50 mg. Riboflavin

100 mg. Niacin

100 mg. Pyridoxine

100 mg. Dihydroxyacetone

100 mg. Inositol

100 mg. Calcium

100 mg. Magnesium

100 mg. Zinc

100 mg. Copper

100 mg. Iron

100 mg. Manganese

100 mg. Cobalt

100 mg. Chromium

100 mg. Molybdenum

100 mg. Boron

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FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM's. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM's. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11077

1. PLACE OF DEATH a. COUNTY Hartford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston		c. LENGTH OF STAY IN fb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 64 Laurel Brook Road		d. STREET ADDRESS Box 64 Laurel Brook Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BORDEN	Middle B.	Last PARRISH
4. DATE OF DEATH	Month August	Day 19	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Feb 21 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Koppers Co	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Williamson L. Parrish		14. MOTHER'S MAIDEN NAME Vernie Barricks	
15. SOCIAL SECURITY NO.		17. INFORMANT Family Records	
18. MEDICAL CERTIFICATION PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) F9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>	M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.	Address (Street, city, town, or county) Moreland Memorial Park Balto Md.		22. DATE SIGNED August 20, 1967
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/23/67	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd.	ADDRESS	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15ME (5 6M 1/67)		DATE AUG 23 1967	

100% of the
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11078

FOR STATE
HEALTH DEPT.

11078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Hartford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 2 hrs.		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital	
3. NAME OF DECEASED (Type or print) HAROLD		First GLENN	Middle PATRICK
4. DATE OF DEATH August 19 1967	Month Day Year	5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Jan. 19, 1928	9. AGE (In years lost birthday) 39 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY State Roads	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William G. Patrick	14. MOTHER'S MAIDEN NAME Florence Pennington	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-26-7607
17. INFORMANT Mrs. Harold Patrick	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Pancreatic abscess and peritonitis DUE TO 587.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute or chronic pancreatitis DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Address
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED August 20, 1967
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-22-1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS West Nottingham Cem.
24. FUNERAL DIRECTOR Jernonett Mullin	23d. LOCATION (City or Town) (County) (State) Colora Cecil Md.	25a. RECEIVED BY REGISTRAR AUG 22 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

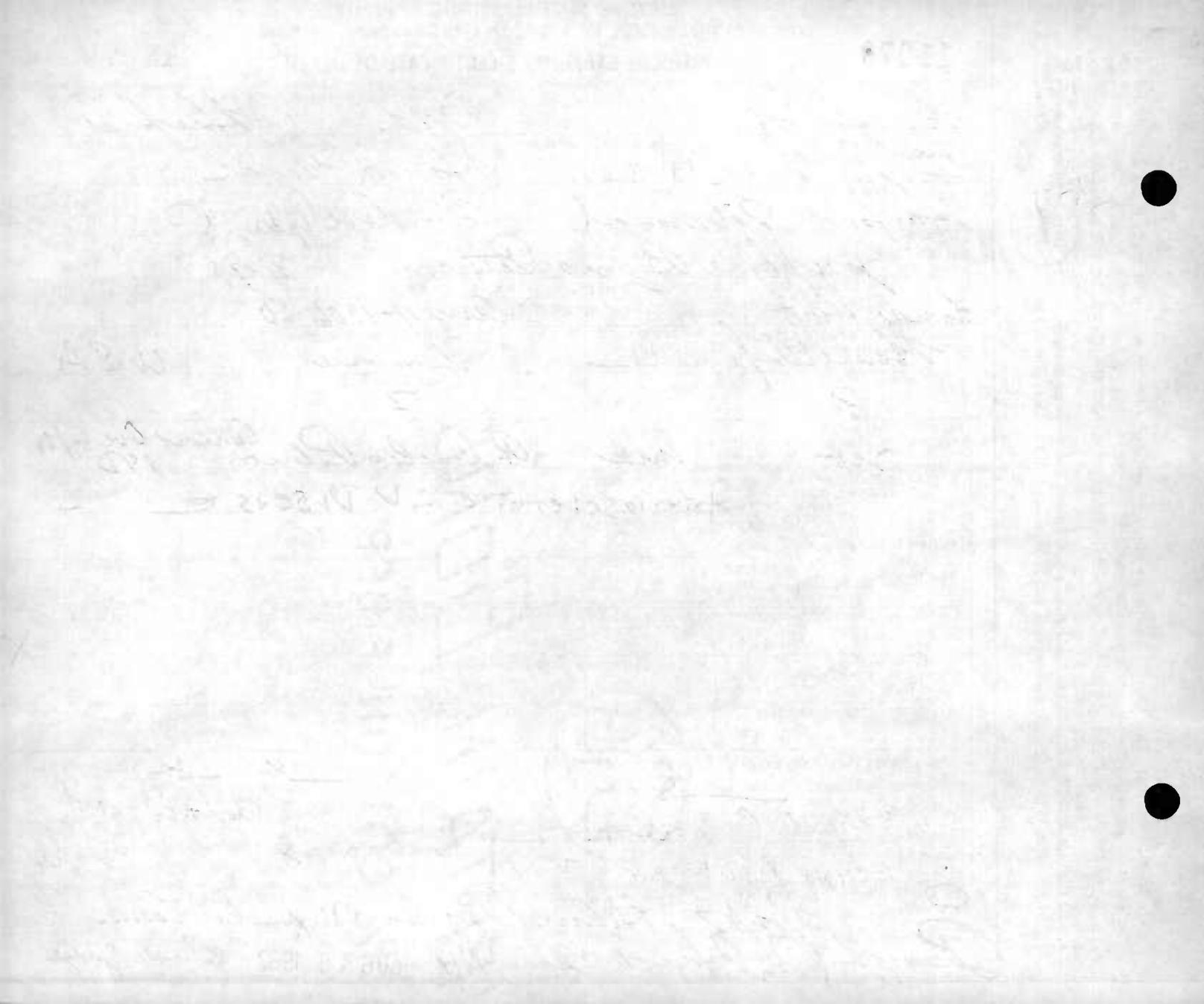
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11079

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Fairfax Chase Md</i>		c. LENGTH OF STAY IN 1b <i>90 A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Josephine Burns Peterson</i>		First <i>Josephine</i>	Middle <i>Burns</i>
4. DATE OF DEATH Month <i>8/8/67</i>		Lost <i></i>	Day Year <i>1967</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug 11 1906</i>		9. AGE (In years lost birthday) yrs. <i>60</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>1mb</i>	
17. INFORMANT <i>R. Douglas Peterson</i>		Address <i>Concord Ave Apts 14D</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Arteriosclerotic CV Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
DUE TO <i>4221</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Donald E. Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Donald E. Palmer</i>		22. DATE SIGNED <i>8/8/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>		23b. DATE THEREOF <i>8/8/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Hilland Park</i>
23d. LOCATION (City or Town) (County) (State)		23e. ADDRESS <i></i>	
24. FUNERAL DIRECTOR <i>Burroughs Son, Harford Chase, Md</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 10 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11080

CERTIFICATE OF DEATH

11080

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hause de Grace</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>(Box 372) Ady Road</u>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Harry</u>	Middle <u>Mitchell</u>	Last <u>Price</u>
4. DATE OF DEATH	Month <u>August</u>	Day <u>14</u>	Year <u>1967</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 14, 1914</u>
9. AGE (In years last birthday) <u>52 yrs.</u>	10. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George E. Price</u>	14. MOTHER'S MAIDEN NAME <u>Mary B. Tawney</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>212-12-5940</u>		17. INFORMANT <u>(With)</u> <u>Mrs. Gertrude M. Price</u>	Address <u>T.R.F.D., Box 372 Forest Hill, Md. 21050</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture thoracic aortic aneurysm (constricting)</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AS CVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Bel Air</u> (County) <u>Harford Co.</u> (State) <u>Maryland</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 14</u> , 1967, to <u>Aug 14</u> , 1967, that (I) (we) last saw the deceased alive on <u>Aug 14</u> , 1967, and that death occurred at <u>10A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>C. W. Grigoleit MD</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. W. Grigoleit</u>		22d. ADDRESS <u>Hause de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 17, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens</u>
23d. LOCATION (City or Town) <u>Bel Air</u> (County) <u>Harford Co.</u> (State) <u>Maryland</u>		23e. ADDRESS <u>W. Broadway & Williams St.</u>	
24. FUNERAL DIRECTOR <u>Jos Eph William Foster</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE
25c. DATE <u>AUG 16 1967</u>			

FOR STATE
HEALTH DEPT.



To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

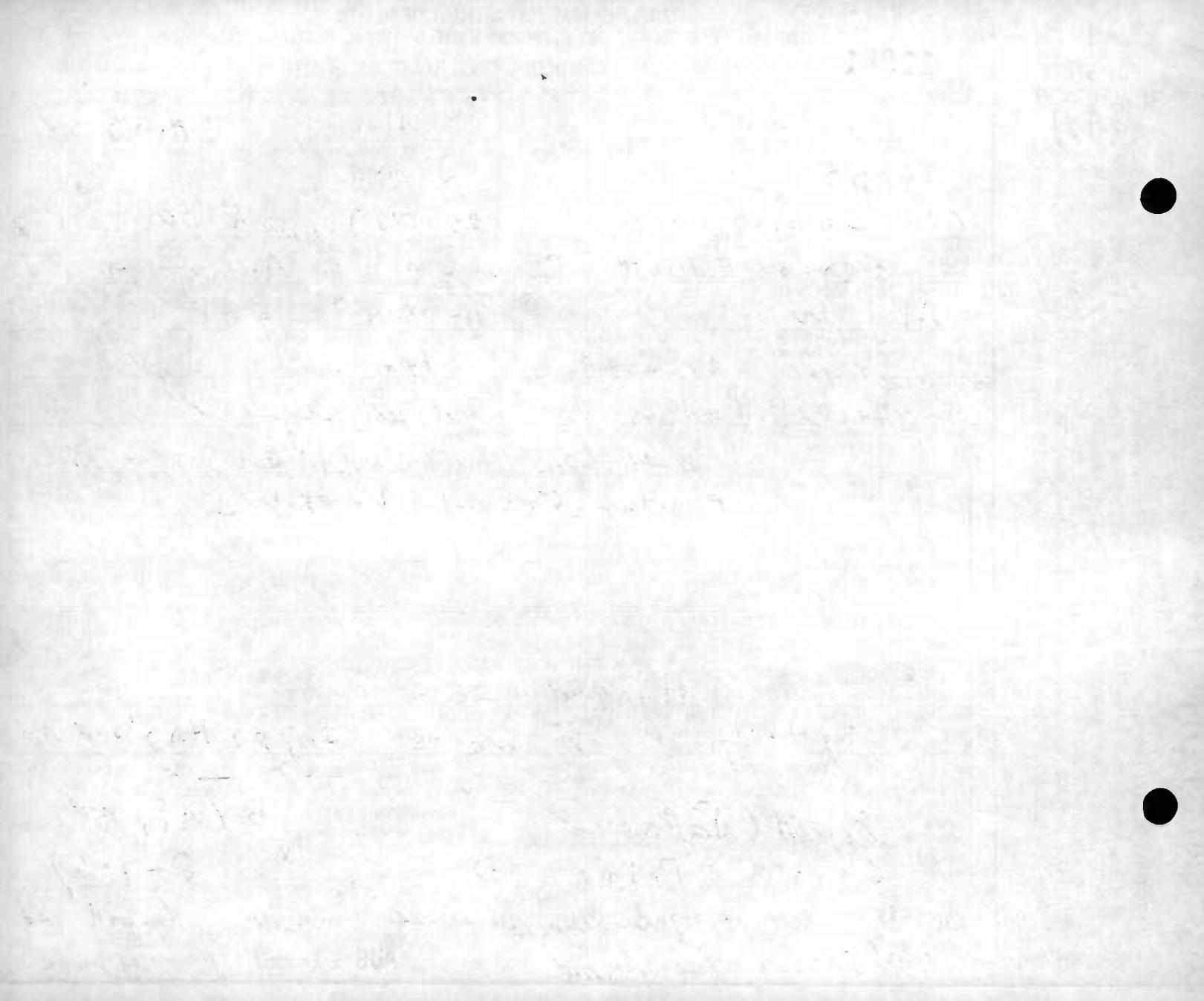
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11081

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jopps</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jopps</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Old Jopps Road</i>		d. STREET ADDRESS <i>2511 Old Jopps Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Gordon E. Elliott Purdum</i>		First <i>G</i> Middle <i>E</i> Last <i>Purdum</i>	4. DATE OF DEATH Month <i>August</i> Day <i>9</i> Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-19-47</i>
9. AGE (In years last birthday) yrs. <i>19</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11. BIRTHPLACE (State or foreign country) <i>Jopps Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Raymond G. Purdum Sr</i>		14. MOTHER'S MAIDEN NAME <i>Mildred Regler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-46-2765</i>	
17. INFORMANT <i>Mrs Mildred Purdum Jopps Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Fracture Cervical Vertebra</i>			
DUE TO <i>974X</i>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hanged self</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>August 8</i> Day <i>9</i> Year <i>1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Walls</i>
20f. (City or town) <i>Jopps</i> (County) <i>Harford</i> (State) <i>Md.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Beth Air, Md</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>22. DATE SIGNED</i> <i>8-9-67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 10, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Beth Air. Memorial</i>
23d. LOCATION (City or Town) <i>Beth Air</i> (County) <i>Harford</i> (State) <i>Md.</i>		23e. LOCATION (City or Town) <i>Beth Air</i> (County) <i>Harford</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Masterch, Benson Md</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>AUG 11 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>James George Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11082

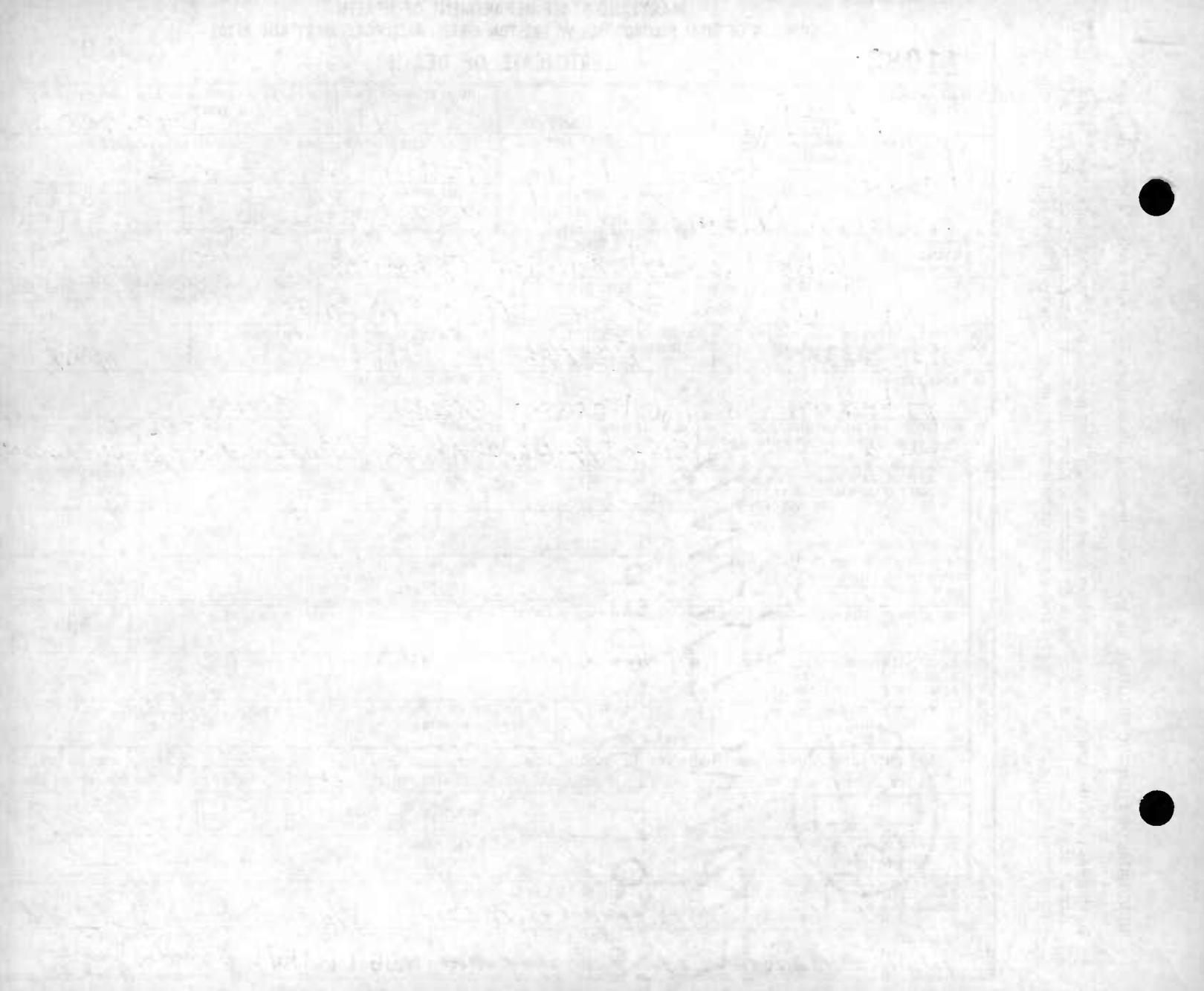
11082

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <i>Harford Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles Alexander Richardson</i>		First <i>Charles</i>	Middle <i>Alexander</i>
4. DATE OF DEATH Month <i>Aug. 14</i>		Last <i>Richardson</i>	Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Aug. 8, 1890</i>		9. AGE (In years last birthday) <i>87 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alexander</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-03-7446</i>	
17. INFORMANT <i>Wm. Kemp Richardson</i>		Address <i>2020 7 Rodman St Hollywood, Fla. 32033</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ascorb</i> DUE TO (c) <i>Chronic myocarditis</i> DUE TO			
INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>August 14, 1967</i> , to <i>August 14, 1967</i> , that (I) (we) last saw the deceased alive on <i>August 14, 1967</i> , and that death occurred at <i>6:55 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>E. J. Simon</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <i>8/14/67</i>
22c. PHYSICIAN'S NAME (Type) <i>E. J. Simon</i>		22d. ADDRESS <i>Havre de Grace</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 17, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Angel Hill Cem.</i>
24. FUNERAL DIRECTOR <i>R. Madison Mitchell</i>		ADDRESS <i>Havre de Grace, Md.</i>	25a. RECEIVED BY REGISTRAR <i>DAUG 17 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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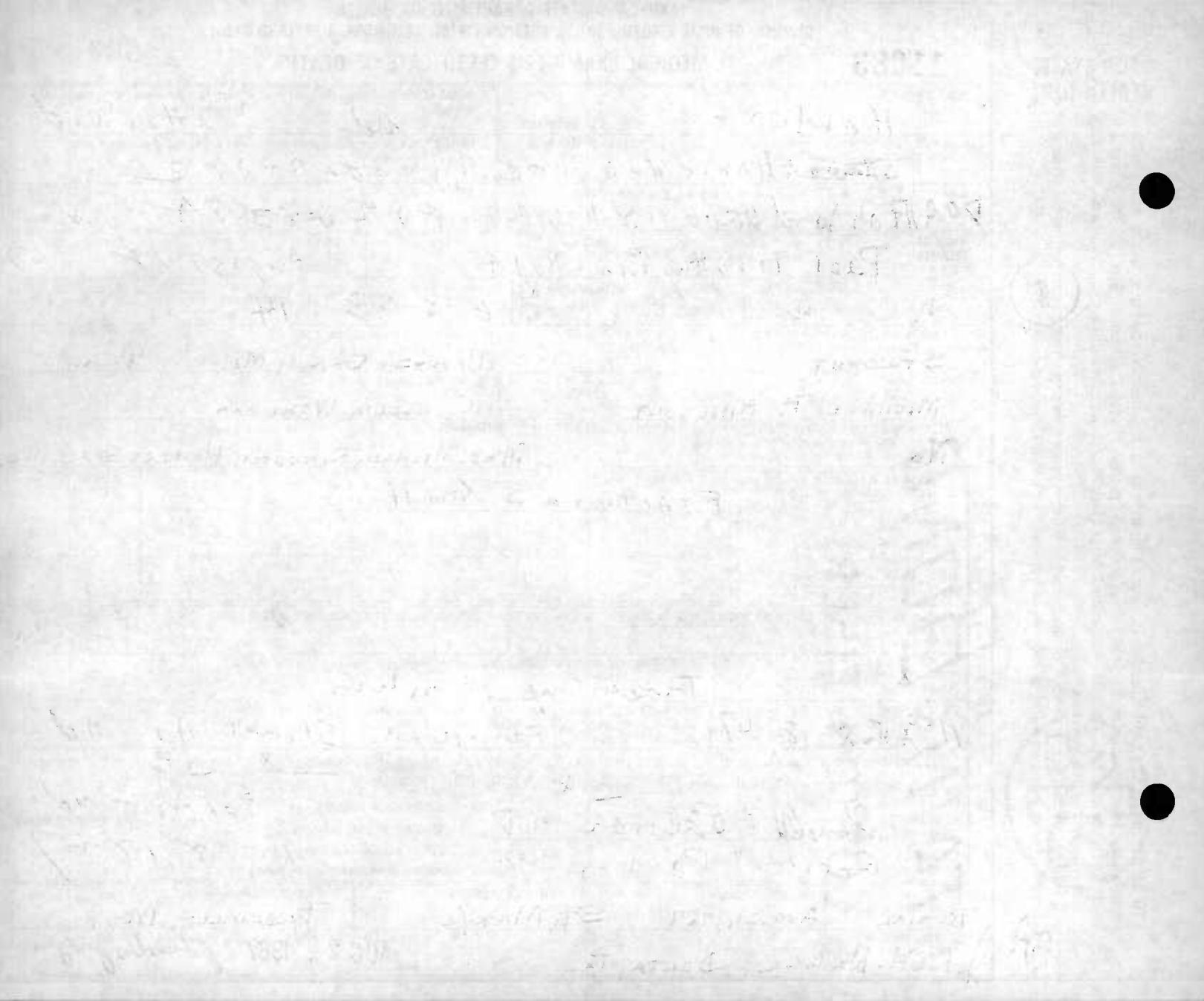
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11083

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hanford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sainte-Havre de Grace</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOAR Hanford Memorial Hospital</i>		d. STREET ADDRESS <i>RD 2 Box 308A</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul Timothy Rineholt		First	Middle
		Last	4. DATE OF DEATH AUGUST 18 1967
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL P. RINEHOLT		14. MOTHER'S MAIDEN NAME CORDELIA WORKMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Michael Rineholt, Havre de Grace, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Faulty no 5 Run DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor upset on him	
20c. TIME OF INJURY Month, Day, Year 11/5 AM 8-18 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm Road
20f. (City or town) (County) (State) Street H. - Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lerold C Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Lerold C Palmer M.D.		22. DATE SIGNED 8-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S
24. FUNERAL DIRECTOR John H. Hartman, DELTA, Pa.		23d. LOCATION (City or Town) (County) (State) Tylerville, Md.	
		ADDRESS	25a. REC'D BY REGISTRAR DATE Aug 22 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one event, within 72 hours after death.

11084		11084	
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> 13-1	
d. STREET ADDRESS <u>107 Stokes St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Regina</u> Middle <u></u> Last <u>Rosentretter</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16-1906</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Linton</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Lloyd Rosentretter</u>		Address <u>107 N. Stokes St Hammond, Harford, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>0021</u> DUE TO <u></u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration, due to diarrhea.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> , 19 <u>67</u> , to <u>8/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>67</u> , and that death occurred at <u>8/3</u> M, from causes and on the date stated above.		22d. DATE SIGNED	
22a. SIGNATURE <u>Dr. Rosentretter</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Angel Hill</u>		23d. LOCATION (City or Town) <u>Hammond, Harford, Md.</u> (County) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE <u>Aug 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1881 1 314

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11085

CERTIFICATE OF DEATH

11085

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Hazre de Grace</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Aberdeen</i>		d. STREET ADDRESS <i>310 Baltimore St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>GRASON</i>	Middle <i>Rowe</i>
4. DATE OF DEATH Month <i>August</i> Day <i>31</i> Year <i>1967</i>		Lost	Month <i>August</i> Day <i>31</i> Year <i>1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2, 1896</i>
9. AGE (In years lost birthday) <i>71 yrs.</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Vet. Admin.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Glooucester, Mass.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Nelson C. Rowe (D)</i>	14. MOTHER'S MAIDEN NAME <i>Augusta Handspaker (D)</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>WW-II Yes</i>		16. SOCIAL SECURITY NO. <i>213-40-1674</i>	17. INFORMANT Address <i>W.N. Rowe, Newark, Delaware</i>
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pleural effusion to atelectasis.</i> DUE TO <i>410X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Mitral + aortic Valvulitis</i> DUE TO <i>lost.</i> (c) <i>Atherosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6-13-1967 to 8-31-1967</i>
20f. (City or town) <i>6-13-1967 to 8-31-1967</i>		(County) <i>6-13-1967 to 8-31-1967</i>	(State) <i>6-13-1967 to 8-31-1967</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 31 1967</i> , and that death occurred of <i>6-13-1967</i> , at (I) (we) lost saw the deceased alive on <i>Aug 31 1967</i> , and that death occurred of <i>6-13-1967</i> , M, from causes and on the date stated above.		22b. DATE SIGNED <i>9-2-67</i>	
22a. SIGNATURE <i>Peter P. Rodman, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6 Sep. 67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington National</i>
23d. LOCATION (City or Town) <i>Ft. Myer, Virginia</i>		(County) <i>Ft. Myer, Virginia</i>	(State) <i>Ft. Myer, Virginia</i>
24. FUNERAL DIRECTOR <i>Tarring Funeral Home</i>		25a. REC'D BY REGISTRAR <i>SEP 6 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>
		ADDRESS <i>Aberdeen, Md.</i>	DATE <i>SEP 6 1967</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11086

CERTIFICATE OF DEATH

11086

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Forest Hill		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chestnut Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Effie	First ----- Shumate	Middle -----	Last -----
4. DATE OF DEATH August 1, 1967	Month August	Day 1	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 19, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Operator	10b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg. Co.	11. BIRTHPLACE (County & State, or foreign country) Trousdale, Grayson Co., Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Merideith Billings	14. MOTHER'S MAIDEN NAME Della Caudill	9. AGE (In years last birthday) 53 yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 215-24-9329	17. INFORMANT (Husband) 838-6169 R.F.D., Box #354 Mr. George W. Shumate Forest Hill, Md. 21050	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung		INTERVAL BETWEEN ONSET AND DEATH 4 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases to liver, bone.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-7, 1967 , to 8-1, 1967 , that (I) (we) last saw the deceased alive on 7-31, 1967 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
22a. SIGNATURE F. O. Hodous		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.	22b. DATE SIGNED August 1, 1967
22c. PHYSICIAN'S NAME (Type) F. O. Hodous		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sharon Baptist Ch. Cem.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster		23d. LOCATION (City, town or county) Forest Hill, Harf. Co., Md.	(State)
25a. REC'D. BY REGISTRAR AUG 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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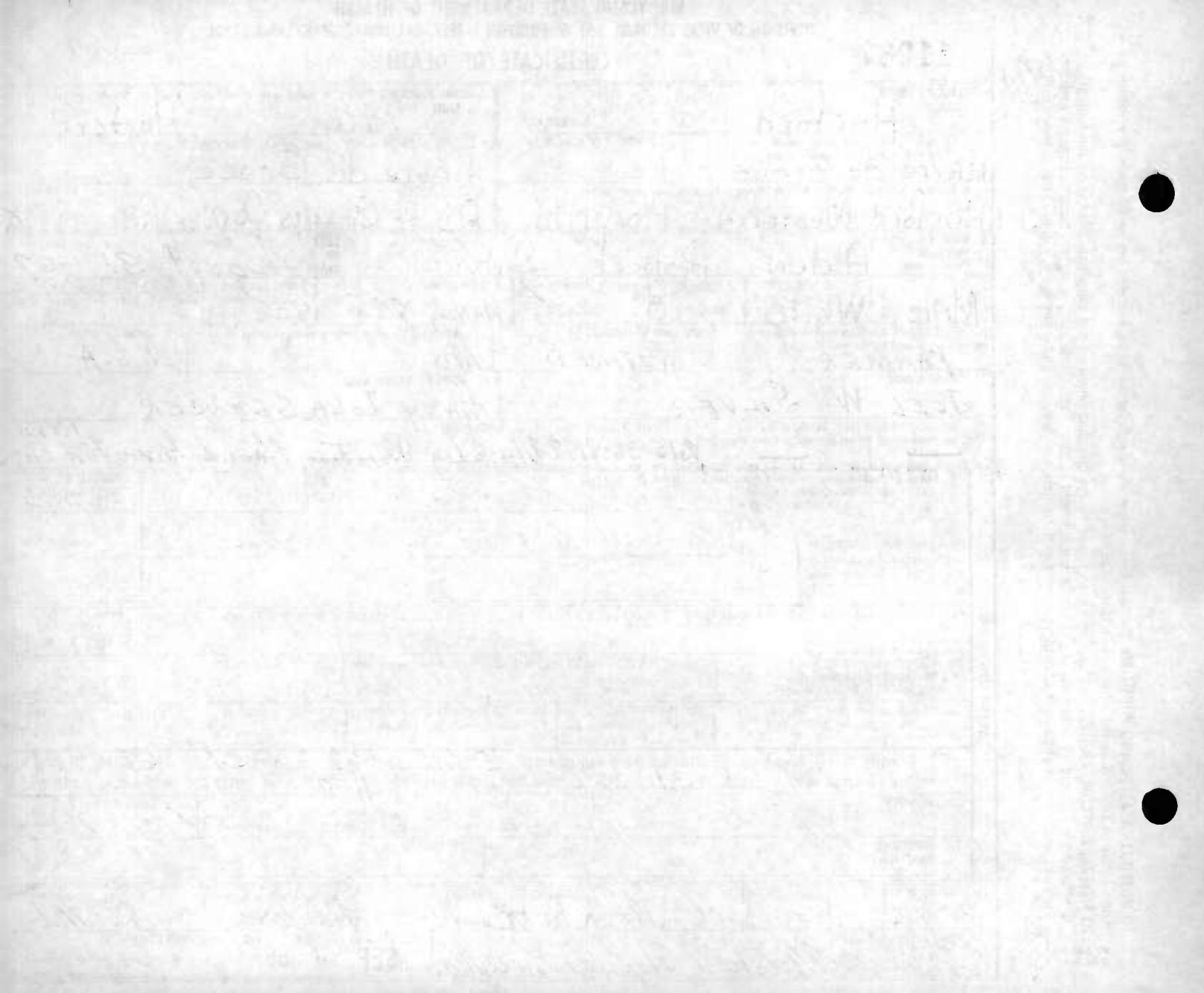
11087

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		d. STREET ADDRESS RD 2 - Craigs Corner Rd				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Alden		First Robert	Middle Silver	Lost August 31	4. DATE OF DEATH Month August	Doy 31	Year 1967			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARS 1885	9. AGE (In years from last birthday) 82	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY PETIRIED		11. BIRTHPLACE (County & State, or foreign country) No.		12. CITIZEN OF WHAT COUNTRY? A.S.A.				
13. FATHER'S NAME JOEL W. SILVER		14. MOTHER'S MAIDEN NAME MARY IOLA SPENCER								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 215-36-8177		17. INFORMANT Mrs. Eleg. Preston, Havre de Grace Md. 21075		Address R.D. 1, Box 77, Havre de Grace, Md. 21075				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221		Cerebrovascular Accident				INTERVAL BETWEEN ONSET AND DEATH 56 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)		DUE TO Arteriosclerotic CVD Disease				5 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Harford	(County) Co. Md.	(State) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8-29 , 1967, to 8-31 , 1967, that (I) (we) last saw the deceased alive on 8-31 , 1967, and that death occurred at 1130 M, fram causes and on the date stated above.										
22a. SIGNATURE J. Ralph Harford, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) J. Ralph Harford, M.D.		22d. ADDRESS				22e. DATE SIGNED 8/11/67				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 3, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Rock Run Mem.		23d. LOCATION (City or Town) Harford		(County) Co. Md.		
24. FUNERAL DIRECTOR R. Madison Mitchell, Havre de Grace, Md.		ADDRESS		25a. RECD. BY REGISTRAR DATE SEP 6 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones		(State)		



MARYLAND STATE DEPARTMENT OF HEALTH

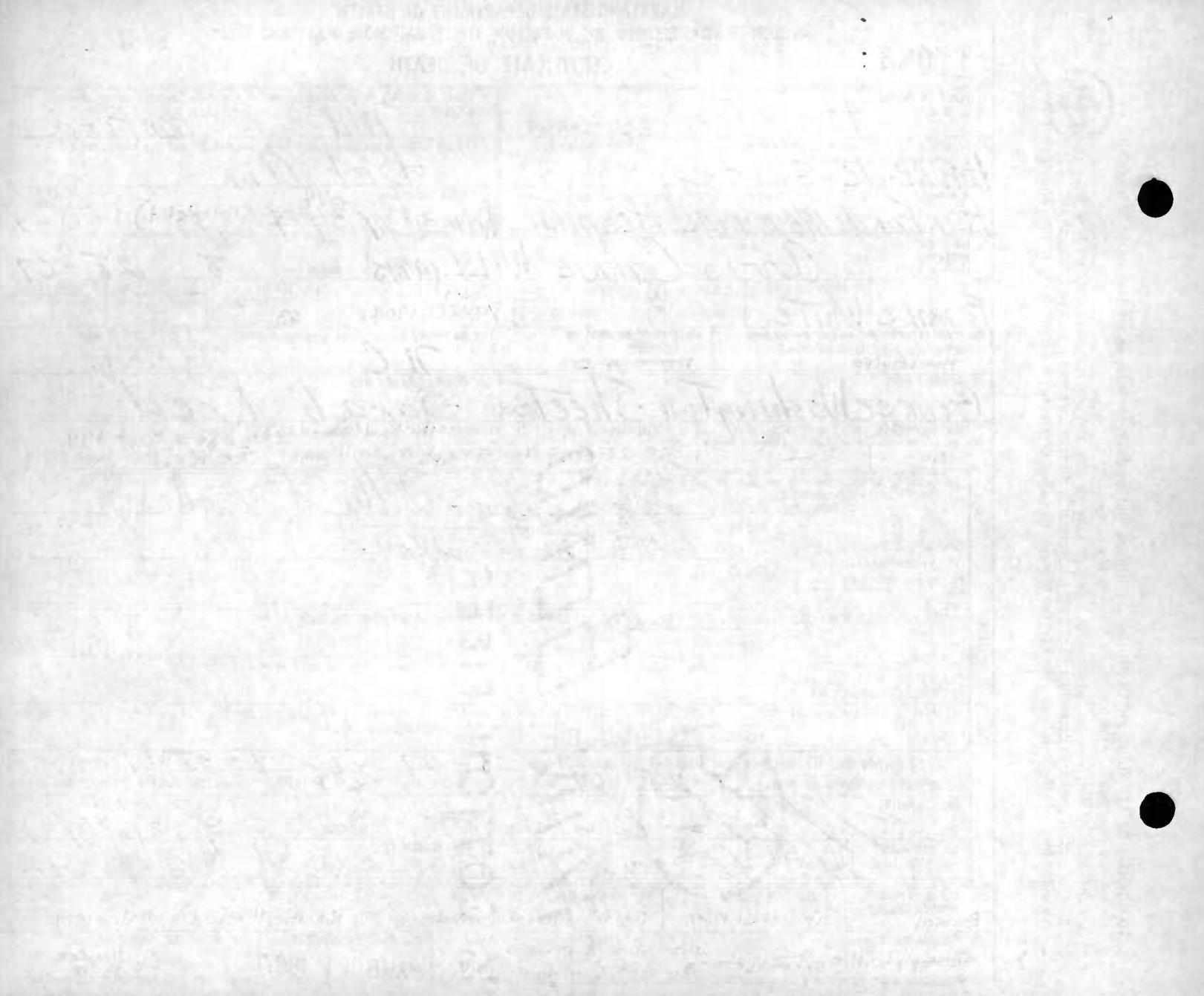
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G392 9/6/67 ph

11088

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Harford</i> MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
<i>Havre-de-Grace</i>	<i>1 day</i>	<i>Harford</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Harford Memorial Hospital</i>	<i>Bel Air</i>		
d. STREET ADDRESS <i>Pd#3 Box 347 Tollgate Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Arvis</i>	Middle <i>Carrie</i>
		Lost. <i>W</i>	4. DATE OF DEATH Month <i>8</i> Day <i>28</i> Year <i>1967</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1904</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	11. BIRTHPLACE (County & State, or foreign country) <i>N.C.</i>
13. FATHER'S NAME <i>George Washington Sheets</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Reed.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>230-22-0019</i>	17. INFORMANT (Husband (838-4263) Address <i>Mr. Joseph M. Williams</i> <i>RFD#3, Box #374 Bel Air, Maryland 21014</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>151X</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. } (b) <i>perforation of the Stomach with metastases</i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Bel Air</i> (County) <i>Harford Co.</i> (State) <i>Md.</i>		21. I certify that (I) (this hospital) attended the deceased from <i>8-27, 1967</i> to <i>8-28, 1967</i> , that (I) (we) last saw the deceased alive on <i>8-28, 1967</i> , and that death occurred at <i>6:30 PM</i> , from causes and on the date stated above.	
22a. SIGNATURE <i>W.H. Sadowsky</i>		22b. DATE SIGNED <i>8/28/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Sadowsky</i>		22d. ADDRESS <i>504 Lewis St. Havre de Grace</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>August 31, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>W. Broadway & Williams St.</i>
23d. LOCATION (City or Town) <i>Bel Air, Harford Co., Md.</i> (County) <i>21014</i> (State)		23e. REC'D BY REGISTRAR <i>J Charles Judge</i> DATE <i>AUG 31 1967</i>	
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.**

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 3009 Glendale Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Convalescent Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY			First E.	Middle WITTHAUER	Last	4. DATE OF DEATH August 19, 1967			Month August	Doy 19	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 16, 1886.			9. AGE (In years last birthday) 81 yrs.			IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William White						14. MOTHER'S MAIDEN NAME Mary Jane Oswald					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unk.			17. INFORMANT Rev. Lawrence H. Jongewaard, Belair, Md.			Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease INTERVAL BETWEEN ONSET AND DEATH _____ 4221 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause _____ (b) _____ last. _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ P.m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 67 , to 8-19, 1967 , that (I) (we) last saw the deceased alive on 8-18 1967 , and that death occurred at 12:30 PM causes and on the date stated above.											
22a. SIGNATURE Gerald E Palmer			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Gerald E Palmer, M.D.			22d. ADDRESS Belair, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/22/67.			23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE AUG 22 1967			25b. REGISTRAR'S SIGNATURE J. Ruck		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Bureau Page 5 may be retained for your files.

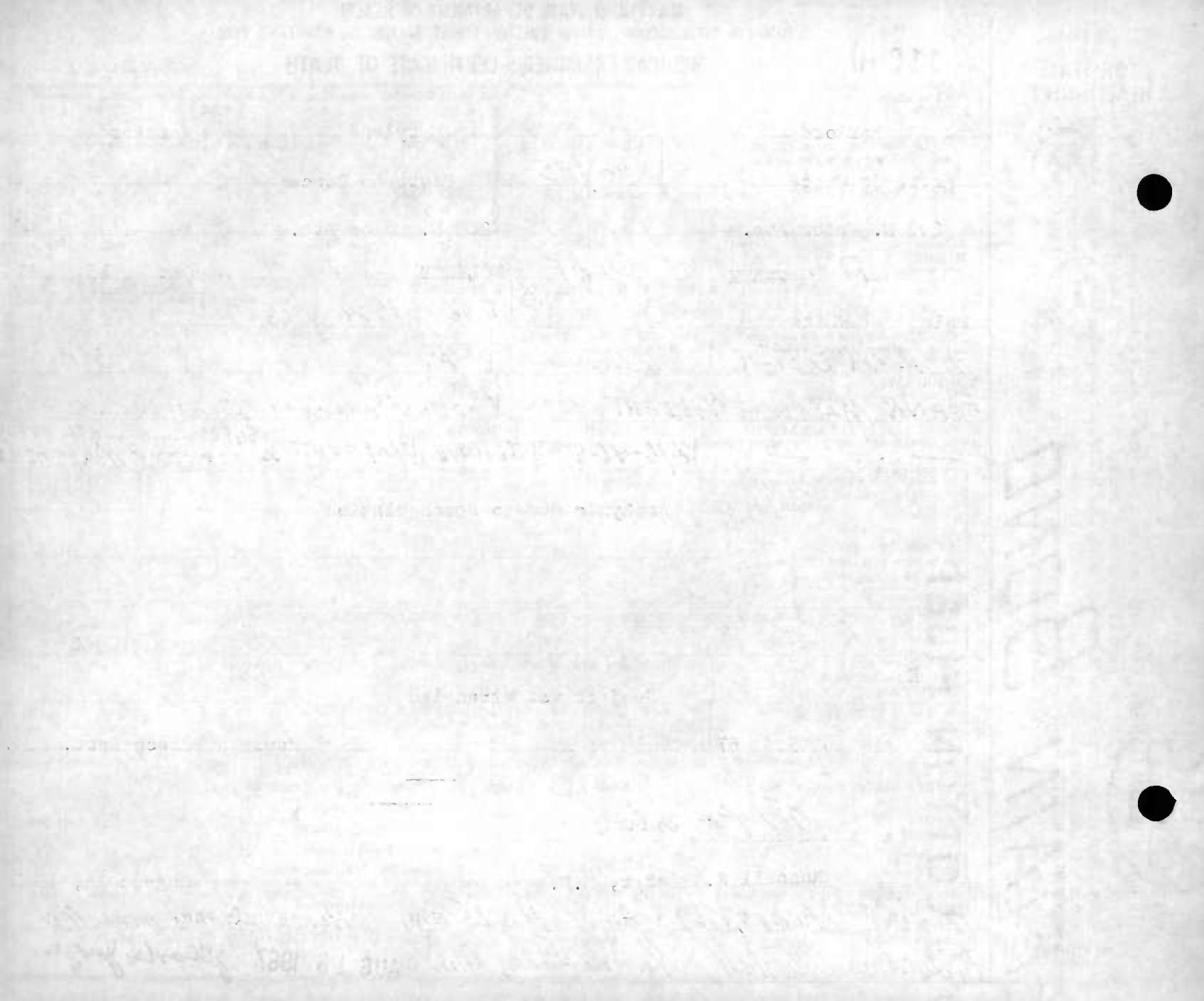
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11091

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 30 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 N. Union Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DR. FRANK OLAF WOLBERT		First	Middle
4. DATE OF DEATH JUNE 12, 1967		Month	Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JUNE 12, 1904		9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medicine	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK MAURICE WOLBERT	
14. MOTHER'S MAIDEN NAME CAROLYN CHAMPNEY BURLINGAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. 216-46-8796	
17. INFORMANT JOHN N. WOLBERT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20a. EXTERNAL CAUSE WAS PRIMARILY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Subject was strangled	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 8 15 19 67		20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED August 16, 1967	
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Russell S. Fisher, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug 18, 1967	23c. NAME OF CEMETERY OR CREMATORIUM ANGEL HILL CEM.
24. FUNERAL DIRECTOR R. Madison Mitchell, Havre de Grace, Md.		ADDRESS	25a. REC'D BY REGISTRAR Charles J. Charles
		DAT	25b. REGISTRAR'S SIGNATURE AUG 18 1967



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11092

1. PLACE OF DEATH a. COUNTY <i>Hagerstown</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hagerstown</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i> D.O.A. c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOY Hospital, Maryland 121 Hwy. Td/</i>		d. STREET ADDRESS <i>James Run Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Teresa Dawn Wood</i>		4. DATE OF DEATH <i>August 7 1967</i>	Month Day Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1964</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>Harford Co., Maryland</i>
13. FATHER'S NAME <i>James Robert Wood</i>		14. MOTHER'S MAIDEN NAME <i>Carol Ann Syke</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT(Father) <i>Mr. James R. Wood</i> Address <i>Tr. Rd #1, Box # 210-A Aberdeen, Maryland</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Internal Injuries</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: <i>Auto Accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto Accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour am <i>6</i> p.m. <i>8-7 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4191 W 21</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) <i>Aberdeen</i> (County) <i>MD</i> (State)	
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>B. C. Palmer</i>	
EXAMINER'S NAME (Type) <i>Gerald C. Palmer - MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>8-8-67</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>August 10, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>
23d. LOCATION (City or Town) (County) (State) <i>Bel Air, Harford Co., Maryland 21014</i>		23e. REG'D BY REGISTRAR DATE <i>AUG 9 1967</i>	
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
W. Broadway & Williams St. Bel Air, Maryland 21014		ADDRESS	

023-121

100,000

023 treatment, 030000

water with lime

023-121
flowing water, 030000

023-121 treatment, 030000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

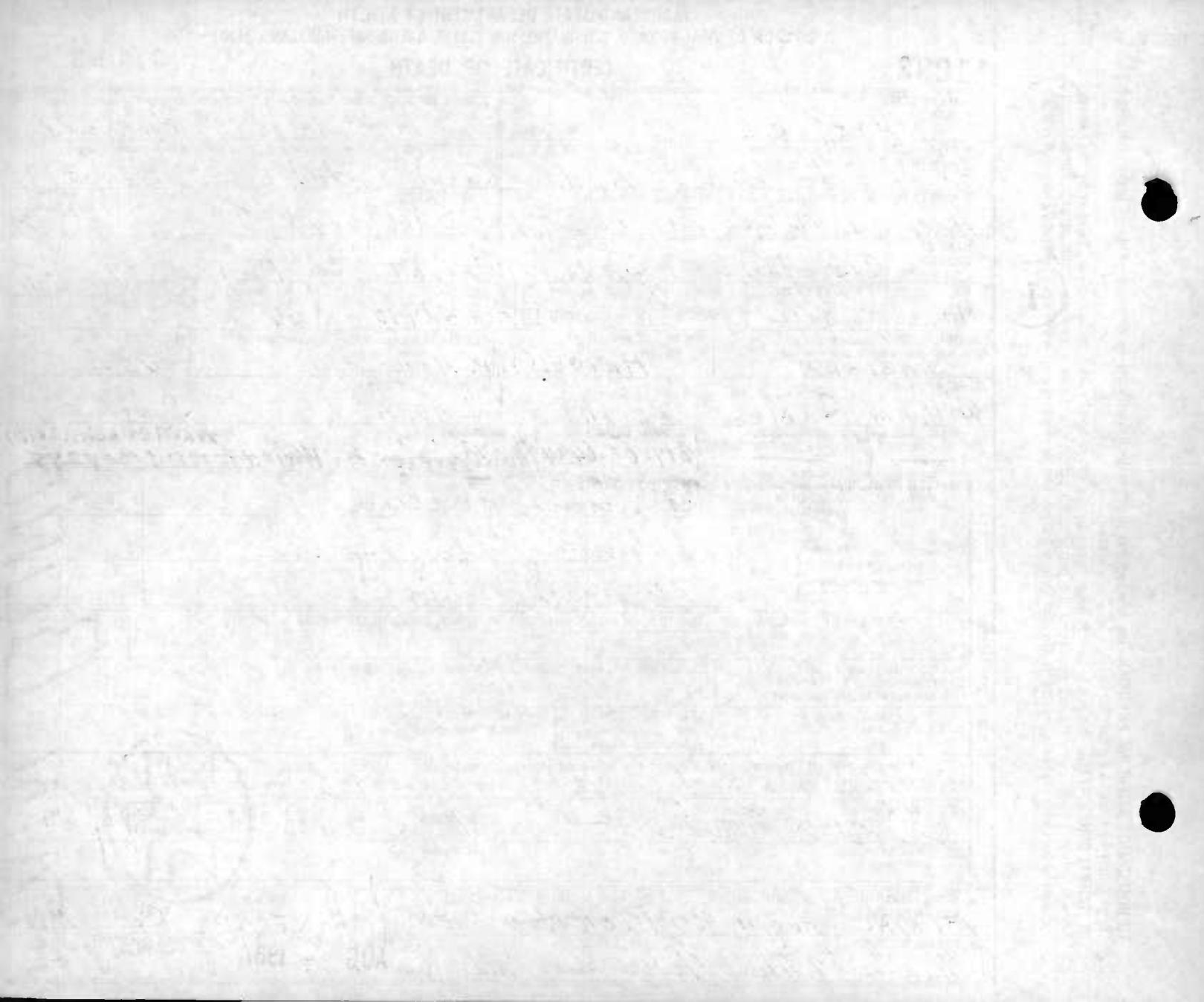
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11092

CERTIFICATE OF DEATH

11093

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cleveland		First JAMES	Middle Wright
Last Wright		4. DATE OF DEATH August 1 1967	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH AUG. 5, 1910
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY HEXCEL Corp. MARYLAND	
13. FATHER'S NAME William James		11. BIRTHPLACE (County & State, or foreign country) Laura	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. 217-03-6434		17. INFORMANT Mr. Bracie E. Wright RD. 1 Box 298	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vulnerability			
(c) Angiopspena			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-21 1967 to 8-1 1967 , that (I) (we) last saw the deceased alive on 8-1 1967 , and that death occurred at 9 AM , from causes and on the date stated above.		22b. DATE SIGNED 8/1/67	
22c. PHYSICIAN'S NAME (Type) Dr. W. Wilson		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF Aug. 4, 1967	
24. FUNERAL DIRECTOR R. Madison Mitchell Harford Grace Md.		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rock Ron Cem	
25a. RECD BY REGISTRAR DATE AUG 4 1967		23b. REGISTRAR'S SIGNATURE James Judge	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film #G392 9/18/67

11094

11093

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de Grace	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS 1205 HANSON Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank	First	Middle	YATES
4. DATE OF DEATH August 31 1967	Month	Doy	Year
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 24, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	9. AGE (In years lost birthday) 61 yrs.
13. FATHER'S NAME Columbus Yates (D)		11. BIRTHPLACE (County & State, or foreign country) Grundy, Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-09-4694	12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT Ronald D. Yates		Address Edgewood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421 DUE TO <i>Cardiac decompensation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. S. C.V.D. DUE TO — (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Cerebral vascular insufficiency</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 7-31, 1967, to 8/31, 1967, that (I) (we) lost saw the deceased alive on Aug. 31, 1967, and that death occurred at 4:15 P.M. from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Edward C. Loo, M.D.		22b. DATE SIGNED 8/31/67	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2 Sep. 67	23c. NAME OF CEMETERY OR CREMATORIAL Harford Memorial Gardens, Aberdeen	23d. LOCATION (City or Town) (County) (State) Md.
24. FUNERAL DIRECTOR John G. Loo	ADDRESS	25a. REC'D BY REGISTRAR SEP 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
Tanning Funeral Home, Aberdeen, Md.			

simply, and the model is as follows:

(1) vector control (2) only induction

knows about himself in this way

technique, unreported in some papers, to give S. D.

132 by a sonnet of 100 words